Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SCD BACK AND JOINT CLINIC LTD
200 EAST 24TH STREET SUITE B
BRYAN TEXAS 77803

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TRAVELERS INDEMNITY CO OF CONN

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-05-8083-01

MFDR Date Received

May 10, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In summary, all treatment/supplies were reasonable and necessary for the treatment of [injured employee's] work related injury, and were submitted to the carrier following current TWCC guidelines. Please reconsider reimbursement in the amount of $1,545.21. See attached table of disputed services. Please respond to all of our claim submissions. There has been no response from the carrier for dates of service 07/22/2004 – 07/29/2004."

Amount in Dispute: $355.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "All bills were paid timely."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2004 through August 3, 2004	95851, 99211, L1499, 99212, 99080, 98943, and 99213	$355.84	$165.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Former 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. Former 28 Texas Administrative Code §133.106, sets out the reimbursement for copies of medical documentation.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Date of service 5/11/2004, CPT code 95851: W1 – Workers compensation state fee schedule adjustment. If reduction, then processed according to the Texas fee guidelines.
   - Date of service 5/11/2004, CPT code 95851: 97 – Payment is included in the allowance for another service/procedure. This procedure is considered integral to the primary procedure billed.
   - Date of service 6/4/2004, CPT code 99211: 97 – Pymt is included in the allowance for another service/px. The service listed under this px code are included in a more comp code which accurately describes the entire px(s) per-formed.
   - Date of service 6/4/2004, HCPCS code L1499: 16 – Claim/service lacks information needed for adjudication. Add'l info is supplied in remittance advice codes when appropriate. The f/s does not allow reimbursement for on-valid codes. Please resubmit w/correct CPT code.
   - Date of service 6/10/2004, CPT code 99212: 97 – Pymt is included in the allowance for another service/px. The service listed under this px code are included in a more comp code which accurately describes the entire px(s) per-formed.
   - Date of service 6/14/2004, CPT code 99211: 97 – Pymt is included in the allowance for another service/px. The service listed under this px code are included in a more comp code which accurately describes the entire px(s) per-formed; G – The procedure code has been rebundled to a more comprehensive code that more accurately describes the entire procedure performed.
   - Date of service 7/1/2004, CPT code 99080: W1 – Workers compensation state fee schedule adjustment. This procedure/service code is reimbursed based on your state workers' compensation medical fee schedule.
   - Date of service 7/16/2004, CPT code 98943: W1 – Workers compensation state f/s adj. Payment denied based on Medicare payment policy; N – Service/procedure doesn't appear to be medically necessary/appropriate.
   - Date of service 7/29/2004, CPT code 99213: 97 – Pymt is included in the allowance for another service/px. The service listed under this px code are included in a more comp code which accurately describes the entire px(s) per-formed.
   - Date of service 8/3/2004, CPT code 98943: W1 – Workers compensation state fee schedule adjustment. If reduction, then processed according to the Texas Fee Guidelines; N – Service/procedure doesn't appear to be medically necessary/appropriate.

Issues

1. Did the requestor bill for unbundled services?
2. Did the requestor submit documentation to support the billing of the disputed CPT codes?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT code 98943 and HCPC code L1499?
4. Is the requestor entitled to reimbursement?

Findings

1. Former 28 Texas Administrative Code §133.106, titled Fair and Reasonable Fees for Required Reports and Records sets out the reimbursement for copies of medical documentation.
   - Date of service July 1, 2004; Disputed CPT code 99080 x 2. Two charges of 121 pages each of copies of medical documentation provided to the RME doctor
   - The first charge, the requestor billed for 121 pages of medical records provided to the RME doctor.
   - The insurance carrier paid the requestor the amount of $50.00.
   - The requestor seeks an additional reimbursement of $10.50.
   - Reimbursement is calculated at $.50/page x 121 pages = MAR $60.50.
   - The requestor is therefore entitled to additional reimbursement in the amount of $10.50.
   - The requestor seeks an additional reimbursement for date of service July 1, 2004 indicating that an additional 121 pages were provided to the RME doctor.
   - The insurance carrier did not pay for an additional 121 pages.
   - The requestor has not provided documentation to support that the RME doctor was provided a total of 242 pages of medical records. Therefore, the division is unable to recommend reimbursement for the second charge of 121 pages for date of service July 1, 2004.

2. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service December 8, 2004. Review of the CCI edits finds:
    - Date of service May 11, 2004; Disputed CPT code 95851 x 2; CPT codes billed 97750-MT, 95851 x 2, and 99213. CCI Edit - Procedure 99213 and component procedure 95851 are unbundled. A modifier is not allowed. Reimbursement is therefore not recommended for CPT code 95851 x 2.
    - Date of service June 4, 2004; Disputed HCPCS codes 99211 and L1499; CPT codes billed 99211, 97750-MT, L1499 and A9150. No CCI edit conflicts were identified. The disputed charge will be reviewed according to the applicable fee guidelines.
    - Date of service June 10, 2004; Disputed CPT code 99212; CPT code billed 99212, 97012, 97110, 97150, 97139-EU, 97124. No CCI edit conflicts were identified. The disputed charge will be reviewed according to the applicable fee guidelines.
    - Date of service June 14, 2004; Disputed CPT code 99211; CPT codes billed 99211, 97110 and 97150. No CCI edit conflicts were identified. The disputed charge will be reviewed according to the applicable fee guidelines.
    - Date of service July 16, 2004; Disputed CPT code 98943; CPT code billed 98943. The requestor billed for one CPT code on July 16, 2004. The disputed charges will be reviewed according to the applicable fee guidelines.
    - Date of service July 29, 2004; Disputed CPT code 99213; CPT codes billed 99213, 99080-73, 97750-MT, 95851 x2. CCI Edit - Procedure 99213 and component procedure 95851 are unbundled. A modifier is not allowed. The requestor seeks resolution of CPT code 99213. No CCI edit conflicts were identified. The disputed charge will be reviewed according to the applicable fee guidelines.
    - Date of service August 3, 2004; Disputed CPT code 98943; CPT codes billed 99212-25, 97024, 97139-EU, 97124, 98943, 99080-73, 98940 and 97012. No CCI edit conflicts were identified. The disputed charge will be reviewed according to the applicable fee guidelines.
3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%... (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule...." Review of the submitted documentation finds:
    - The requestor submitted documentation to support that the services billed were rendered. The requestor is therefore entitled to Medicare reimbursement x 125% = maximum allowable reimbursement (MAR).
    - Date of service June 4, 2004; Disputed CPT code 99211. The Medicare fee schedule is $19.55 x 125% = MAR $24.43. The requestor seeks $23.35, this amount is recommended.
    - Date of service June 10, 2004; Disputed CPT code 99212. The Medicare fee schedule is $35.33 x 125% = MAR $44.16. The requestor seeks $41.91, this amount is recommended.
    - Date of service June 14, 2004; Disputed CPT code 99211. The Medicare fee schedule is $19.55 x 125% = MAR $24.43. The requestor seeks $23.35, this amount is recommended.
    - Date of service July 29, 2004; Disputed CPT code 99213. The Medicare fee schedule is $49.58 x 125% = MAR $61.97. The requestor seeks $58.99, this amount is recommended.
4. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.

- Disputed CPT code 98943 rendered on July 16, 2004 and August 3, 2004 is not valued by Medicare.
- Disputed HCPCS code L1499 rendered on June 4, 2004 is not valued by CGS Medicare's DMEPOS fee schedule (cgsmedicare.com) or the Texas Medicaid Fee schedule.
- CPT code 98943 and HCPC code L1499 are therefore subject to the provisions of 28 Texas Administrative Code §134.1.

Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor billed HCPC code L1499 on June 4, 2004 and CPT codes 98943 rendered on July 16, 2004 and August 3, 2004.
- The procedure codes indicated above do not have a Medicare or Texas Medicaid assigned value.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- The requestor did not provide documentation to demonstrate how it determined it's usual and customary charges for HCPC code L1499 and CPT code 98943.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Payment cannot be recommended for HCPC code L1499 and CPT code 98943.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $165.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $165.49 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

		April 22, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.